

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/20/2012	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a post survey revisit (PSR) to investigation of Complaint IN00101601 completed on 1/13/2012.</p> <p>This visit included the PSR to the Recertification and State Licensure survey completed on 12/7/2011.</p> <p>Complaint IN00101601 - Corrected</p> <p>Survey date: February 20, 2012</p> <p>Facility number: 001144 Provider number: 155668 AIM number: 200256980</p> <p>Survey team: Gloria J. Reisert MSW/TC Donna Groan RN Avona Connell Dorothy Navetta</p> <p>Census bed type: SNF: 56 SNF/NF: 58 Residential: 9 Total: 123</p> <p>Census payor type: Medicare: 20 Medicaid: 38 Other: 65 Total: 123</p> <p>Sample: 3</p> <p>Providence Retirement Home was found to be in</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/20/2012	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	Continued From page 1 compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the post survey revisit to the investigation of Complaint IN00101601. Quality review completed 2/21/12 Cathy Emswiller RN			{F 000}			